



**CONFLICT OF CONSCIENCE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Department: \_\_\_\_\_

Please describe the treatment/procedure you are requesting not to participate in: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does this treatment/procedure conflict with your values or beliefs? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Member's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Director/Manager's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Circle One:      Approved      Denied

Reason, if denied \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Maintain this document in the staff member's departmental file.**